CASEREVIEW

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November 16, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar Epidural Block Under Fluoroscopy L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a Board Certified Anesthesiologist with over 7 years of experience, including Pain Management.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is XX year old female who was injured on XX/XX/XX when lifting property from X onto a table cart. She felt immediate pain in her lower back. She went to the ER and originally saw Dr for medication and PT.

On July 15, 2015, MRI of the Lumbar Spine, Impression: 1. Mild discogenic disease at the L3-L4 and L4-L5 levels as described above. 2. No evidence of high-grade canal stenosis or high-grade neural foraminal narrowing at any level. 3. Exiting and traversing nerve roots do not appear contacted at any level. 4. Mild inflammatory endplate change at L3-L4 and minimal degenerative change of the facet joints which could be a source of non radicular low back pain. 5. Slight straightening of the lumbar spine which could be secondary to patient positioning versus muscle spasm. 6. Findings very similar to prior study from 7/19/14.

On August 5, 2015, the claimant presented with an increase in symptoms, including a lower back pain level of 9 and radiating pain into the left leg with associated numbness and tingling. Lower extremity weakness had resolved. On examination, ROM remained the same. Muscle spasm along the paraspinal muscles remained the same. Tenderness remained the same. (no prior exams were provided) Deep tendon reflexes were normal. Sensation was normal. Muscle strength was normal. Sitting SLR was positive bilaterally. Diagnosis: Right sprain of thoracic and lumbar spine. Bilateral Lumbago. Bilateral Intervertebral disc disorder with myelopathy of the lumbar region. Bilateral Sciatica. Plan: Continue physical therapy, Mobic 15 mg and Flexeril 10 mg.

On August 19, 2015, the claimant presented reporting overall a decrease in symptoms. Pain level had decreased to a 6, radiating pain into the left leg had decreased, numbness and tingling had also decreased into the left leg. On examination there was full ROM. Muscle spasm and tenderness remained the same. Deep tendon reflexes were normal. Sensation was normal. Muscle strength was normal. SLR was negative. Recommendations: 1. Physical therapy evaluation. 2. Discontinue previous medications and start Mobic 15 mg and Skelaxin 800 mg. 3. Refer for ESI.

On September 2, 2015, the claimant presented reporting overall symptoms had remained the same. Recommendations: 1. No PT at this time. 2. Discontinue previous medications and start Mobic 15 mg and Flexeril 10 mg. 3. Pending ESI appointment.

On September 17, 2015, the claimant presented reporting overall symptoms had remained the same. Recommendations: 1. No PT at this time. 2. Mobic 15 mg and Flexeril 10 mg. 3. Pending ESI appointment.

On September 24, 2015, UR. Rationale for Denial: The evidence-based guidelines recommend consideration for epidural steroid injections when radiculopathy is documented by exam and corroborated by imaging and/or electrodiagnostic testing. In this case, the patient's MRI from July 15, 2015 did not demonstrate any indication of canal stenosis or neural foraminal narrowing at any level. The exiting and traversing nerve roots did not appear to be contacted at any level. Examination on September 2, 2015 was not consistent with a focal neurologic deficit to cause concern for current active radiculopathy. As such, the patient is not a candidate for an epidural injection.

On October 13, 2015, UR. Rationale for Denial: Within the associated medical file, there is documentation of a previous request for Lumbar Epidural Block Under Fluoroscopy that was non-certified as the MRI did not demonstrate any indication of canal stenosis or neural foraminal narrowing at any level and the exiting and traversing nerve roots did not appear to be contacted at any level, and the physical examination was not consistent with a focal neurological deficit to cause concern for current active radiculopathy. In addition, there is documentation of failure of conservative treatment (activity modification, medications, and physical modalities). However, despite nonspecific documentation of subjective findings (low back pain with radiating pain, numbness, and tingling that has decreased) findings, there is no specific (to a S1 nerve root distribution) documentation of subjective (pain, numbness, or tingling) radicular findings in the requested nerve root distribution. In addition, given documentation of objective (deep tendon reflexes normal, sensation normal, muscle strength normal) findings, there is no documentation of objective (sensory changes, motor changes, or reflex changes) radicular findings in the requested nerve root distribution. Furthermore, given documentation of imaging findings (lumbar spine MRI identifying no evidence of high-grade canal stenosis or high-grade neural foraminal narrowing at any level; exiting and traversing nerve roots do not appear to be contacted at any level; and at L5-S1 no spinal stenosis, or foraminal stenosis), there is no documentation of imaging (MRI) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels. Lastly, there is no documentation of a Discussion/Rationale as to why such may not be applicable.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse determinations are upheld. To justify the requested procedure as medically necessary, per guidelines, there must be radiculopathy present documented by exam and corroborated by imaging and/or electrodiagnostic testing. In this case, the patient's MRI from July 15, 2015 did not demonstrate any indication of canal stenosis or neural foraminal narrowing at any level. The exiting and traversing nerve roots did not appear to be contacted at any level. Examination on September 2, 2015 was not consistent with a focal neurologic deficit to cause concern for current active radiculopathy. Therefore, this request for Lumbar Epidural Block Under Fluoroscopy L5-S1 is non-certified.

PER ODG:

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

(1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, muscle relaxants & neuropathic drugs).

(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.

(4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.

(5) No more than two nerve root levels should be injected using transforaminal blocks.

(6) No more than one interlaminar level should be injected at one session.

(7) *Therapeutic phase:* If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)

(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

(9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.

(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.

(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**